Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

MEMORIAL HERMANN SURGERY CENTER
9200 PINECROFT SUITE 200
THE WOODLANDS TX 77380

Respondent Name

HARTFORD UNDERWRITERS INSURANCE

Carrier's Austin Representative Box

Box Number 47

MFDR Tracking Number

M4-11-0569-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary dated July 7, 2010: "Please review the above mentioned claim. Per the TWCC contract the allowed amount for this claim should be $4,083.06 (see attached)."

Requestor's Supplemental Position Summary dated November 16, 2010: "Per your fax that we received on 11-10-10, when we billed the carrier we included the invoice for the implants and the OP report. When we appeal the claim on 7-7-10 we again requested reimbursement for the implants. When we appealed the claim with TWCC we again requested payment for the implants and included the invoice and the OP report again. We are confused as your fax stated we did not request separate reimbursement for the implants?????"

Amount in Dispute: $1608.61

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary dated November 5, 2010: "Carrier reimbursed in accordance with Rule 134.402(f). The provider did not request separate reimbursement for the implants in accordance Rule 134.402(g)(1)."

Respondent's Supplemental Position Summary dated December 21, 2010: "Please be advised that per Coventry no provider agreement exists for the above date of service."

Response Submitted by: The Hartford, 300 S. State St., Syracuse, NY 13202

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 28, 2010	ASC Services for code 11012	-$69.39	$0.00
	ASC Services for code 21360	-$794.03	$0.00
	HCPCS code L8699	$2472.03	$0.00

TOTAL		$1608.61	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.402, titled *Ambulatory Surgical Center Fee Guideline*, effective August 31, 2008, sets out the reimbursement guidelines for ambulatory surgical care services.
3. Texas Labor Code Ann. §413.011(d-3) states the division may request copies of each contract and that the insurance carrier may be required to pay fees in accordance with the division's fee guidelines if the contract is not provided in a timely manner to the division.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated June 30, 2010
   - W1-WC state fee sched adjust. Reimbursement according to the Texas medical fee guidelines.
   - 217-The charges have been discounted per review by QMEDTRIX's billcheck service.
   - 45-Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. No ASC Group associated with this procedure or not separately reimbursable to ASC.

   Explanation of benefits dated September 1, 2010
   - 193-Original payment decision is being maintained. Reimbursement for your no additional monies are being paid at this time. Bill has been paid according to state fee guidelines or rules and regulations.
   - 45-Charge exceeds fee schedule/max allowable or contracted/legislated fee arrangement. Reimbursement for resubmitted invoice has been considered. No additional monies are being paid at this time. Bill has been paid according to PPO contract.

   Explanation of benefits dated September 28, 2010
   - 193-Original payment decision is being maintained. Reimbursement for your no additional monies are being paid at this time. Bill has been paid according to state fee guidelines or rules and regulations.
   - 45-Charge exceeds fee schedule/max allowable or contracted/legislated fee arrangement. Reimbursement for resubmitted invoice has been considered. No additional monies are being paid at this time. Bill has been paid according to PPO contract.

   Explanation of benefits not dated
   - 217-Based on payer reasonable and customary fees. No maximum allowable defined by legislated fee arrangement. (Note: To be used for Workers' Compensation only).
   - W1-Workers Compensation state fee schedule adjustment.

Issues

1. Does the submitted documentation support a contract exist between the parties for the disputed services?
2. Did the requestor support position that separate reimbursement for implantables was requested?
3. Did the requestor support position that the respondent did not pay the ASC services for code 11012 in accordance with 28 Texas Administrative Code §134.402? Is the requestor entitled to reimbursement?
4. Did the requestor support position that the respondent did not pay the ASC services for code 21360 in accordance with 28 Texas Administrative Code §134.402? Is the requestor entitled to reimbursement?

Findings

1. According to the explanation of benefits, the carrier paid the services in dispute in accordance with a contracted or legislated fee arrangement. Texas Labor Code Ann. §413.011(d-3) states the division may request copies of each contract under which fee are being paid, and goes on to state that the insurance carrier may be required to pay fees in accordance with the division's fee guidelines if the contract is not provided in a timely manner to the division.

   On December 6, 2010, the Division submitted a notice requesting a copy of the contract between the network and the health care provider in this dispute. The insurance carrier's representative acknowledged receipt of the notice on December 7, 2010. The notice provided for a deadline to submit the requested information no later than fourteen (14) days after receipt of the notice.

The respondent submitted a supplemental position summary that states “Please be advised that per Coventry no provider agreement exists for the above date of service.” For that reason, the services in dispute will be reviewed in accordance with 28 Texas Administrative Code §134.402.

2. The requestor states in the supplemental position summary that “Per your fax that we received on 11-10-10, when we billed the carrier we included the invoice for the implants and the OP report. When we appeal the claim on 7-7-10 we again requested reimbursement for the implants. When we appealed the claim with TWCC we again requested payment for the implants and included the invoice and the OP report again. We are confused as your fax stated we did not request separate reimbursement for the implants?????”

   The respondent states in the position summary that “The provider did not request separate reimbursement for the implants in accordance Rule 134.402(g)(1).”

   The requestor billed HCPCS code L8699 for the implantables.

   HCPCS code L8699 is defined as “Prosthetic implant, not otherwise specified.”

   28 Texas Administrative Code §134.402(g)(1)(A) and (B) states “A facility, or surgical implant provider with written agreement of the facility, may request separate reimbursement for an implantable.
   (1) The facility or surgical implant provider requesting reimbursement for the implantable shall:
   (A) bill for the implantable on the Medicare-specific billing form for ASCs;
   (B) include with the billing a certification that the amount billed represents the actual cost (net amount, exclusive of rebates and discounts) for the implantable. The certification shall include the following sentence: "I hereby certify under penalty of law that the following is the true and correct actual cost to the best of my knowledge," and shall be signed by an authorized representative of the facility or surgical implant provider who has personal knowledge of the cost of the implantable and any rebates or discounts to which the facility or surgical implant provider may be entitled.”
   A review of the submitted medical bill does not support that separate reimbursement for the implantable was requested by the provider. In additional, the requestor did not submit a certification that the amount billed represents the actual cost for the implantable per 28 Texas Administrative Code §134.402(g)(1)(B). The Division concludes that the requestor did not support position that separate reimbursement for implantables was requested per 28 Texas Administrative Code §134.402(g)(1)(A) and (B). The Division further concludes that for the disputed services, reimbursement is applicable to 28 Texas Administrative Code §134.402(f)(1)(A).

3. 28 Texas Administrative Code §134.402(d) states “ For coding, billing, and reporting, of facility services covered in this rule, Texas workers' compensation system participants shall apply the Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in this section.”

   28 Texas Administrative Code §134.402(f)(1)(A) states “The reimbursement calculation used for establishing the MAR shall be the Medicare ASC reimbursement amount determined by applying the most recently adopted and effective Medicare Payment System Policies for Services Furnished in Ambulatory Surgical Centers and Outpatient Prospective Payment System reimbursement formula and factors as published annually in the *Federal Register*. Reimbursement shall be based on the fully implemented payment amount as in ADDENDUM AA, ASC COVERED SURGICAL PROCEDURES FOR CY 2008, published in the November 27, 2007 publication of the *Federal Register*, or its successor. The following minimal modifications apply: (1) Reimbursement for non-device intensive procedures shall be: (A) The Medicare ASC facility reimbursement amount multiplied by 235 percent.”

   HCPCS code 11012 is defined as “Debridement including removal of foreign material at the site of an open fracture and/or an open dislocation (eg, excisional debridement); skin, subcutaneous tissue, muscle fascia, muscle, and bone.”

   28 Texas Administrative Code §134.402(f) reimbursement for non-device intensive procedure for code 11012 is:

   The Medicare fully implemented ASC reimbursement rate is found in the Addendum AA ASC Covered Surgical Procedures fully implemented ASC relative payment weight for CY 2010 = 4.0737.

   This number is multiplied by the 2010 Medicare ASC conversion factor of 4.0737 X $41.873 = $170.57.

   The Medicare fully implemented ASC reimbursement rate is divided by 2 = $85.28 ($170.57/2).

   This number X City Conversion Factor/CMS Wage Index for The Woodlands is $85.28 X 0.9841 = $83.92.

   The geographical adjusted ASC rate is obtained by adding half of the national reimbursement and wage adjusted reimbursement $85.28 + $83.92 = $169.20.

   Multiply the geographical adjusted ASC reimbursement by the DWC payment adjustment $169.20 X 235% = $397.62.

CPT code 11012 is subject to multiple procedure discounting; therefore, $397.62 X 50% is $198.81.

The MAR for CPT code 11012 is $198.81. The insurance carrier paid $198.84. As a result, additional reimbursement is not recommended.

4. HCPCS code 21360 is defined as "Open treatment of depressed malar fracture, including zygomatic arch and malar tripod."

   28 Texas Administrative Code §134.402(f) reimbursement for non-device intensive procedure for code 21360 is:

   The Medicare fully implemented ASC reimbursement rate is found in the Addendum AA ASC Covered Surgical Procedures fully implemented ASC relative payment weight for CY 2010 = 23.3111.

   This number is multiplied by the 2010 Medicare ASC conversion factor of 23.3111 X $41.873 = $976.10.

   The Medicare fully implemented ASC reimbursement rate is divided by 2 = $488.05 ($976.10/2).

   This number X City Conversion Factor/CMS Wage Index for The Woodlands is $488.05 X 0.9841 = $480.29.

   The geographical adjusted ASC rate is obtained by adding half of the national reimbursement and wage adjusted reimbursement $488.05 + $480.29 = $968.34.

   Multiply the geographical adjusted ASC reimbursement by the DWC payment adjustment $968.34 X 235% = $2,275.59.

   The MAR for CPT code 21360 is $2,275.59. The insurance carrier paid $2,275.61. As a result, additional reimbursement is not recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that the requestor has not supported its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	2/2/2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.